APPENDIX 1: METHODOLOGY

How were the sites selected?

(See map in the Introduction) A total of 20 sites were studied for this issue of *Pulse Check*. During 2000, we selected sites using Census Bureau regions and divisions with a goal of achieving geographic and demographic diversity. In addition, we made an effort to select sites in areas with special drug abuse problems of national concern. More specifically, we applied the following methodology in selecting sites.

We purposely selected the most populous States in the four census regions: New York in Region I (Northeast Region); Texas in Region II (South Region); Illinois in Region III (Midwest Region); and California in Region IV (West Region). In three of these States, we selected the most populous metropolitan areas: New York City, Chicago, and Los Angeles. In Texas, however, we selected El Paso—a known high trafficking area with particularly high levels of unemployment, population growth, and poverty—because of its proximity to the United States border with Mexico.

We included four rural States, one per census region. (Rural States are defined by the Census Bureau as those in which 50 percent or more of the State's population reside in census-designated rural areas.) The four rural sites selected are as follows:

- Region I (Northeast): Portland, ME—Of the three rural States in the Northeast Region (including New Hampshire and Vermont), Maine has the only Atlantic coastline and shares the longest border with Canada. It also includes an ONDCP-designated High Intensity Drug Trafficking Area (HIDTA). Portland is Maine's most populous metropolitan area.

- Region II (South): Columbia, SC—The three other rural States in the South census region are Kentucky, Mississippi, and West Virginia. However, South Carolina's location along a major drug trafficking corridor makes that State a strategic choice. Recent cocaine seizures in Columbia further highlight its strategic importance.

- Region III (Midwest): Sioux Falls, SD—Sioux Falls is the most populous metropolitan area within the Midwest Region's two rural States (North Dakota and South Dakota).

- Region IV (West): Billings, MT—Montana is the only census-designated rural State in the West Region, and Billings is its most populous metropolitan area.

The remaining 12 sites were selected to ensure that the entire list included at least 2 sites from each of the 9 Census Bureau divisions (East North Central, Mountain, Middle Atlantic, New England, Pacific, South Atlantic, South East Central, South West Central, and West North Central). Additional selection criteria included population density, representation of racial/ethnic minorities, and emphasis on high drug trafficking areas.

Applying these criteria resulted in the final selection of the following 20 *Pulse Check* sites:

Baltimore, MD*
Billings, MT
Boston, MA
Chicago, IL
Columbia, SC
Denver, CO
Detroit, MI
El Paso, TX
Honolulu, HI
Los Angeles, CA
Miami, FL
Memphis, TN
New Orleans, LA
New York City, NY
Philadelphia, PA
Portland, ME
St. Louis, MO
Seattle, WA
Sioux Falls, SD
Washington, DC

How do the 20 sites vary demographically?

Appendix 2 highlights the demographic diversity of these 20 sites. For example, their population density per square kilometer ranges from a sparse 18.6 in Billings, MT, to a crowded 2,931.6 in New York City. Their unemployment rates range from a 2.4 low in Sioux Falls, SD, to a 6.2 high in El Paso, TX. The racial/ethnic breakdowns in the 20 sites further exemplify their diversity: White representation ranges from 21.2 percent in Honolulu, HI, to 96.0 percent in Portland, ME; Black representation ranges from 0.4 percent in Billings, MT, to 43.2 percent in Memphis, TN; and Hispanic representation ranges from less than 1 percent in Portland, ME, to 78.3 percent in El Paso, TX.

**Because of concerns about its unique problems involving heroin and cocaine, Baltimore, MD, was added as a Pulse Check site for the report covering the January–June 2001 period; Birmingham, AL, was dropped as of the July–December 2001 issue in order to maintain balanced geographic representation.*

What other data are available at the 20 selected sites? Information from other national-level data sources will be useful for framing, comparing, corroborating, enhancing, or explaining the information obtained for *Pulse Check*. The following data sources are available in nearly every site: ONDCP's past *Pulse Check* reports; the National Institute on Drug Abuse (NIDA) Community Epidemiology Work Group (CEWG); the Substance Abuse and Mental Health Services Administration (SAMHSA) Drug Abuse Warning Network (DAWN); and the National Institute of Justice (NIJ) Arrestee Drug Abuse Monitoring (ADAM) program.

Who are the Pulse Check sources, and how were they selected? Consistent with previous issues, the information sources for *Pulse Check* were telephone discussions with 4 knowledgeable individuals in each of the 20 sites: 1 ethnographer or epidemiologist, 1 law enforcement official, and 2 treatment providers. Ethnographers and epidemiologists were recruited based on several possible criteria: past participation in the *Pulse Check* program; membership in NIDA's CEWG; research activities in local universities; or service in local community programs. We recruited law enforcement officials by contacting local police department narcotic units, Drug Enforcement Administration (DEA) local offices, and HIDTA directors. All but 2 of the 40 epidemiologists, ethnographers, and law enforcement sources who reported for this issue of *Pulse Check* were the same, or associated with the same agencies, as those who reported for the previous issue.

To identify treatment sources for the Mid-Year 2000 issue of *Pulse Check*, we randomly selected providers from the 1998 Uniform Facility Data Set (UFDS), a listing of Federal, State, local, and private facilities that offer drug abuse and alcoholism treatment services. For this purpose, we excluded facilities that reported more than 50 percent of their clientele as having a primary alcohol abuse problem, served a caseload of fewer than 100 clients, or provided only prevention or detox services. We then divided the remaining facilities into two groups—methadone and non-methadone treatment facilities—in order to capture two client populations whose demographic characteristics and use patterns often differ widely. We selected one from each of these two categories of programs for each of the 20 selected sites. Because Billings, MT, and Sioux Falls, SD, have no UFDS-listed methadone treatment facilities, we selected two non-methadone facilities in those sites.

Since the Mid-Year 2000 issue of *Pulse Check*, in order to preserve continuity, all actively available treatment sources have been retained. Additionally, to ensure regular reporting, any treatment provider who becomes unavailable to participate is being replaced via purposeful, rather than random, selection based on consultation with experts in the field. Altogether, we recruited 40 treatment sources: 18 methadone providers (1 from each *Pulse Check* site except for Billings and Sioux Falls, where methadone treatment is unavailable), and 22 non-methadone providers (1 from each *Pulse Check* site plus extra sources from Billings and Sioux Falls). Thus, a total of 80 sources have been identified and recruited, and for this *Pulse Check* issue we successfully obtained information from 78 of them: a response rate of 98 percent. Two participants were unavailable: one of the two the non-methadone treatment providers from Sioux Falls; and the methadone treatment provider from New Orleans.

What kind of data were collected, and how? For each of the 78 responding sources, we conducted a single telephone discussion lasting about 1 hour. We asked sources to explore with us their perceptions of the change in the drug abuse situation between fall 2001 and spring 2002. We discussed a broad range topic areas with these individuals, as delineated in Appendix 5. Not surprisingly, ethnographic and epidemiologic sources were very knowledgeable about users and patterns of use; they were somewhat knowledgeable about drug availability; and they were less informed about sellers, distribution, and trafficking patterns. Treatment providers had a similar range of knowledge, but they generally focused on the specific populations targeted by their programs. Some providers, however, were able to provide a broader perspective about the communities extending beyond their individual programs. Among the three *Pulse Check* source types, law enforcement officials appeared to be most knowledgeable about drug availability, trafficking patterns, seller characteristics, sales practices, and other local market activities; they were not asked to discuss user groups and characteristics.